Family PACT
Planning • Access • Care • Treatment
OFFICE OF FAMILY PLANNING
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

Volume 5/No.4
Winter 2003

Update

This Issue:

- *Quality Improvement*
- *The Health Impact of Intimate Partner Violence*
- *Family PACT Update*
- *Remembering to Offer Emergency Contraceptives*
- *Frequently Asked Questions*
- *Provider Forums*

Why Quality Improvement?

The secret to success in your clinic/practice is staff who care and clients whose satisfaction with the services bring them back. Family PACT has a new "method" for improving your family planning reproductive health services to insure they are in the spirit of client-centered preventive health care.

COPE® (Client-Oriented Provider-Efficient services) is both a process and a set of tools designed to help health care staff continuously assess and improve the quality of their services. Built on a framework of clients' rights and staff needs COPE® was developed by EngenderHealth (formerly AVSC) for use across the globe to help clinic staff work as a team to improve the quality of their services through manageable and measurable steps.

OFP is offering COPE® as a new provider resource. The pilot phase is now in process, initially recruiting publicly funded clinics only. For more information on COPE® or to invite a COPE® facilitator into your clinic to help you get started, call Abi Brown at (916)731-8115. Requests will be reviewed by OFP staff to determine the best use of resources. ■

The Health Impact of Intimate Partner Violence

Connie Mitchell, MD
Director, Domestic Violence Education
California Medical Training Center

Intimate partner violence is defined by the Centers for Disease Control as physical, sexual violence or threats of physical and sexual violence, psychological/emotional abuse including coercive tactics that adults or adolescent use against current or former intimate partners [1]. The terms intimate partner violence and domestic violence are used interchangeably here.

Prior research suggests that between 960,000 to 4 million individuals are victims of intimate partner violence (IPV) each year and of these about 85% are women [2-4]. In a recent survey conducted by the Commonwealth Fund, it was estimated that approximately one-third of American women will become a victim of IPV at some point in their life [5]. Finally, while men are more likely than women to become a victim of violence, women are 3-5 times more likely than men to be victimized by an intimate partner [5-7].

Prior research on domestic violence using hospital data has generally focused on patients in emergency departments (ED) [7-13]. In 1994, it was estimated that 34% of women who sought treatment for violent injuries in ED's were victims of domestic violence [7]. In the clinic setting, 5.5% of women presenting to an ambulatory setting reported physical violence by an intimate partner within the last year [14]. Data further reports that between 20-40% of IPV victims seek repeated care for abuse [12, 15]. Domestic violence victims usually suffer minor physical injuries and they self treat in private but they also present with serious non-fatal and fatal injuries [10, 15-18].

Identification and diagnosis of intimate partner violence relies on patient disclosure that is either patient initiated or as a result of appropriate inquiry. Clinicians also identify domestic violence through pattern recognition of key historical or physical findings that appear consistent with domestic violence. Due to the powerful negative stigma associated with victimization, clients are reluctant to disclose. Clinician identification of patterns removes that barrier and provides a treatment effect.

Women who have been abused by a partner report significantly lower self assessments of health, increased disabilities and increased chronic health conditions than non-abused women [19]. Other health concerns that have been associated with IPV include functional gastrointestinal disorders, chronic abdominal pain [20], chronic headaches [21], and alcohol and drug addiction [22]. A few studies have established links between sexually transmitted diseases including HIV as women report they can not negotiate for condom use with their abusive partners. [23] [24]

IPV in pregnancy results in increased morbidity and perhaps mortality. Studies suggest that women who are pregnant are at a higher risk of becoming victims of IPV [17, 25]. Between 4-16% of all women who are pregnant are battered during pregnancy [22, 26-29]; 10-32% of women seeking prenatal care have a history of domestic violence [22, 29, 30]; and 40-60% of battered women report being a victim of domestic violence during their pregnancy [17, 25]. The prevalence of abuse in pregnant adolescents appears even greater than that for adult women. [31] [25] Poor outcomes associated with IPV in pregnancy include premature onset of labor, increased antenatal hospitalizations, and low birth weight infants. Maternal rates of depression, suicide attempts, tobacco, alcohol and illicit drug use are higher in

continued on page 2

The Health Impact . . . continued

abused than unabused women. [32] A recent study of death certificates in Maryland revealed that the primary cause of maternal mortality was homicide. [33] Domestic violence victims often have co-morbid health problems that complicate their medical care, and may have socioeconomic or legal problems that further burden the victim's recovery. Children and other dependents in IPV homes may themselves be victims of abuse, neglect or negative outcomes associated with witnessing violence. Perpetrators have increased health problems too but their abusive nature is rarely recognized by health care providers prior to criminal justice involvement. An interdisciplinary coordinated response is usually necessary and case managers become a valuable asset in the process. Community domestic violence agencies generally provide a variety of victim services, both crises and supportive, and can be an invaluable resource for the clinician. Outcome studies are identifying interventions for perpetrators and for victims that appear to reduce the repeat violence and help victims feel safer and healthier but much more research is needed.

Intimate partner violence erodes the health of patients, consumes healthcare dollars, compromises the health and safety of children and communities, and represents a liability exposure for the clinician who turns their head. Healthcare providers must gain experience in the diagnosis and management of IPV so that identification occurs earlier and intervention follows established protocols.

For guidance in establishing protocols to identify and assist victims of intimate partner violence, go to www.familypact.org, click on Educational Events and find "A Practical Clinical Approach to Victims of Domestic Violence." The participant handouts from this Family PACT sponsored audio conference provide a step by step process for developing a protocol and process for your practice site. At the end of the protocol guide there are websites and other resources listed that can be accessed for additional information.

References:

1. Saltzman LE, *Intimate Partner Violence Surveillance*. 1999, Centers for Disease Control and Prevention.
2. DOJ, *Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends and Girlfriends*. 1997, US Department of Justice.
3. Fund TC, *First Comprehensive National Health Survey of American Women*, in *The Commonwealth Fund*. 1993: New York.
4. Greenfeld LA, R.M., et al., *Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends*. Vol. 167237. 1998: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. 1-46.
5. Fund TC, *Health Concerns Across a Woman's Lifespan: The Commonwealth Fund 1998 Survey of Women's Health*. 1999, The Commonwealth Fund: New York, NY.
6. Bachman R, S.L., *Violence against Women: Estimates from the Redesigned Survey*, in *Bureau of Justice Statistics*, S.L. Bachman R, Editor. 1995, U.S. Department of Justice Office of Justice Programs.
7. Rand M, S.K., *Violence-Related Injuries Treated in Hospital Emergency Departments*. Bureau of Justice Statistics, 1997.
8. Roberts GL, O.T.B., Raphael B, et al, *Prevalence Study of Domestic Violence Victims in an Emergency Department*. Ann of Emerg Med, 1996(6): p. 747-53.
9. Roberts GL, *Domestic Violence victims in a hospital emergency department*. Medical Journal of Australia, 1993(159): p. 307-310.
10. Ernst AA, N.T., Weiss SJ, Houry D, Mill T., *Domestic Violence in an Inner-City ED*. Ann of Emerg Med, 1997. 30(2): p. 190-7.
11. McLeer S, A.R., *A Study of Battered Women Presenting in an Emergency Department*. AJPH, 1989. 79(1): p. 65-6.
12. Abbott J., J.R., Koziol-McLain J, Lowenstein SR, *Domestic Violence Against Women Incidence and Prevalence in an Emergency Department Population*. JAMA, 1995. 273(22): p. 1763-67.
13. Goldberg WG, T.M., *Domestic Violence Victims in the Emergency Department New Findings*, in *JAMA*, T.M. Goldberg WG, Editor. 1984. p. 3259-64.
14. McCauley J, K.D., Kolodner K, Dill L, Schroeder AR, DeChant HK, Ryden J, Bass EB, Derogatis LR,, *The "Battering Syndrome": Prevalence and Clinical Characteristics of Domestic Violence in Primary Care Internal Medicine Practices*. Annals of Internal Medicine, 1995. 123(10): p. 737-746.
15. Berios DC, *Domestic Violence: Risk factors and outcomes*. The Western Journal of Medicine, 1991(155).
16. Ganley AL, *Understanding Domestic Violence*, in *Improving the Healthcare Response to Domestic Violence: A Resource Manual for Health Care Providers*, G.A. Warshaw C, eds, Editor. 1996, The Family Violence Prevention Fund: San Francisco, CA. p. 1-14.
17. Rynerson BC, *Violence Against Women*, in *Maternity and Women's Health Care*, B.I. Lowedermilk DL, Perry SE, eds, Editor. 1997, Mosby Press: St. Louis, MO. p. 1220-1241.
18. Sable PR, *What do we know about domestic violence?* The Physicians Guide to Domestic Violence, ed. e. Brown Z. 1995, Volcano City, CA: Volcano Press.
19. Plichta SB, *Prevalence of Violence and Its Implications for Women's Health*. Women's Health Issues, 2001. 11(3): p. 244-58.
20. Drossman D A, N.J.T.L.J., et al, *Sexual and Physical Abuse and Gastrointestinal Illness*. Ann Intern Med, 1995. 123(10): p. 782-94.
21. Domino JF, *Prior physical and sexual abuse in women with chronic headache: Clinical disorders*. Headache, 1987(27): p. 310-4.
22. Amaro H, *Violence during pregnancy and substance abuse*. American Journal of Public Health, 1990(80): p. 575-579.
23. Eby, K.K., Campbell, J.C., Sullivan, C.M., and Davidson, W.S., 2nd, *Health effects of experiences of sexual violence for women with abusive partners*. Health Care Women Int, 1995. 16(6): p. 563-76.
24. Wingood, G.M. and DiClemente, R.J., *The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women*. Am J Public Health, 1997. 87(6): p. 1016-8.
25. Parker B, *Physical and emotional abuse in pregnancy: A comparison of adults and teenage women*. Nursing Research, 1993(42): p. 173-177.
26. McFarlane J, *Physical and emotional abuse during pregnancy: A comparison of adults and teenage women*. Nursing Research, 1993(42): p. 173-177.
27. Campbell JC, *Empowering Survivors of Abuse: Health Care for Battered Women and Their Children*, in *Thousand Oaks, California*, Campbell J.C., Editor. 1998. p. 1 - 332.
28. Moore ML, *Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence*. Journal of Obstetrics, Gynecology, & Neonatal Nursing, 1998(27): p. 175-82.
29. Stewart DE, *Physical abuse during pregnancy*. Canadian Medical Association Journal, 1993(61): p. 1257-1263.
30. Campbell JC, *Correlates of battering during pregnancy*. Research in Nursing and Health, 1992(15): p. 219-226.
31. Berenson, A.B., MD, San Miguel, V.V., JD, MD, and Wilkinson, G.S., PhD, *Prevalence of Physical and Sexual Assault in Pregnant Adolescents*. Journal of Adolescent Health, 1992. 13(6): p. 466-469.
32. McFarlane, J., RN, DrPH, FAAN, Parker, B., RN, PhD, FAAN, and Soeken, K., PhD, *Physical abuse, smoking, and substance use during pregnancy: prevalence, interrelationships, and effects on birth weight*. Journal of Obstetric, Gynecologic, and Neonatal Nursing (JOGNN), 1996. 25(4): p. 313-320.
33. Horon, I.L. and Cheng, D., *Enhanced Surveillance for Pregnancy-Associated Mortality—Maryland, 1993-1998*. JAMA, 2001. 285(11): p. 1455-9.

Family PACT Program Support and System Services

Health Access Programs (HAP) Hotline	**800-257-6900**	**Family PACT Educational Material Ordering (EDS)**	**800-848-7907**
Order HAP cards			
Family PACT billing assistance		**POS/Internet Assistance**	**800-427-1295**
On-site claims consultations		**AEVS Assistance**	**800-456-2387**
Office of Family Planning	**916-654-0357**	**Medi-Cal Fraud Hotline**	**800-822-6222**
Medi-Cal Provider Services/Enrollment	**916-323-1945**		

Remember to Offer Emergency Contraception

by Felicia H. Stewart MD

In the midst of providing medical care to a woman who is escaping violence or involved in a coercive sexual relation, attention to routine prevention steps may seem like a low priority. And it may not be the ideal time for comprehensive family planning information. ***But it is a time when it is critical for a client to have access to emergency contraceptive treatment.*** Intimate partner violence often includes coercion in sexual decisions, and maintaining power over the victim of violence often includes opposition to contraception. Repeated partner rape may even be part of the situation.

The 1992 National Women's Study estimated that 12% of adult women in the United States had experienced at least one rape in their lifetime; 4.7% of these rapes resulted in pregnancy.[1] Although violent crimes including rape have declined overall since 1996, rape incidence for adult and teen women in 2000 are estimated at 25,000 annually.[2] If all women who were raped used emergency contraception, approximately 22,000 pregnancies resulting from rape could potentially be prevented annually.[2]

For the woman just beginning to find a path out of a violent relationship, unintended pregnancy can be a major setback. At the very least, it will be yet one more difficulty that the woman will face at a time when difficulties are many. So asking whether emergency contraception may be needed immediately, providing it, and offering to provide a supply in advance in case it is needed later, are prevention steps that do deserve to be included in crisis medical care for women. Providing testing for sexually transmitted infection, and presumptive treatment if indicated, also should be offered.

Providing emergency contraception treatment is not complicated, and does not require an exam or extensive history. The only key clinical information needed is that unprotected intercourse has occurred within the last 72 hours (or even 120 hours), and that pregnancy is not desired. Whether or not there have been additional prior acts of unprotected intercourse does not really matter. Treatment now can reduce the chance of pregnancy for the recent exposure by 75% to 89%.[3] If a prior act results in fertilization and pregnancy, then treatment now will have no effect. There is no need to be concerned about exposing the woman or a developing embryo to the medication – no evidence indicates that this treatment has any adverse effect even if the woman subsequently decides to continue the pregnancy to term. So the worst case outcome with treatment following multiple exposures is that the treatment does not succeed in preventing pregnancy. The best case is that unwanted pregnancy resulting from the recent exposure is prevented.

> ***"All women who are victims of intimate partner violence need Emergency Contraception."***

Treatment options include progestin-only pills (Plan B) or combination, estrogen and progestin pills (Preven or one of the available oral contraceptive products containing levonorgestrel). Plan B is preferable because it is slightly more effective and has significantly fewer side effects. Principle side effects are nausea and vomiting. Following treatment, the woman should plan to have a pregnancy test if she does not have a normal period within the next 3 weeks. There are no absolute medical contraindications to treatment. Insertion of a copper-bearing IUD also provides extremely effective emergency contraception, but is only appropriate for women who have decided to use IUC as their long term contraceptive method.

With the various emergency contraceptive options available, it is clear that all clients who are victims of violence or involved in coercive sexual relations should have access to those options. That access has the potential of helping the client avoid the future trauma of an unplanned pregnancy.

References

1. Holmes MM, Resnick HS, Kilpatrick DG, Best CL. Rape-related pregnancy estimates and descriptive characteristics from a national sample of women. *Am . Obstet Gynecol* 1996;175:320-5.
2. Stewart FH, Trussell J. Prevention of pregnancy resulting from rape: a neglected preventive health measure. *Am J Prev Med* 2000;19(4):228-229.
3. Trussell J, Rodriguez G, Ellertson C. Updated estimates of the effectiveness of the Y8uzpe regimen of emergency contraception. *Contraception* 1999;59:147-51.

Frequently Asked Questions

- *1. Is an abstinent person eligible for Family PACT services? What primary diagnosis code (S code) is used for abstinence?*

  Any client who is capable of getting pregnant (i.e. fertile) is eligible for Family PACT services depending on income, family size and other health coverage. Prior to the start of sexual intimacy is an excellent time, particularly for young people, to establish a relationship with a reproductive health care provider. It is an opportunity for a private, personal discussion about reproductive health issues, to learn about available contraceptive options, and to think about negotiating relationships. The S 501 or 502 primary diagnosis codes should be used when providing services to clients who have choosen abstinence as their contraceptive method. Abstinent or not, all clients have the option to get condoms and Emergency Contraception.

- *2. If a male patient only wants condoms, is an exam required? How often?*

  All Family PACT clients, including men have a right to a physical exam. Men need to understand the importance of a basic health exam and be encouraged to have the exam as soon as possible. At a minimum, clients should complete a "comprehensive health history" and participate in a discussion about their reproductive goals and contraceptive options before any contraceptive methods are provided. The physical exam and tests for STI's can be deferred, but should be scheduled as soon as possible with the client. The clinician's interpretation of the client history and plan for physical exam should be documented as well as an explanation of individual counseling provided.

- *3. Are "lab panels" available/required for the primary diagnosis codes used in Family PACT?*

  There are no "lab panels" in Family PACT. A variety of lab tests are available as part of the scope of service for each Primary Diagnosis, but specific lab tests should only be ordered for a client if there is a medical justification for the test, i.e individual client indication. Routine testing of all clients with all available tests is not "recognized medical practice." Review the Family PACT *Policies Procedures and Billing Instructions (PPBI)* manual (Sections 18-21) for the required medical conditions that must exist before some tests are covered. ■

Family PACT Update

NEW CONTRACEPTIVE METHODS

The Office of Family Planning (OFP) is pleased to announce the addition of the NuvaRing® vaginal ring and ORTHO EVRA™ Transdermal patch as new Family PACT forumulary items. These methods are hormonal contraceptives, similar to oral contraceptives in mode of action, effectiveness and side effects. One advantage over oral contraceptives is that both methods provide a steady dose of hormones that may reduce spotting and help regulate menstrual cycles. The dosage schedule is easier than taking a birth control pill every day. Vaginal rings are changed monthly and the patch is changed weekly.

ATTENTION ALL FRONT AND BACK OFFICE STAFF

The Family PACT Program manual, *Policies, Procedure and Billing Instructions (PPBI)* has been updated. Changes and additions to the Family PACT program have been incorporated into two sets of replacement PPBI pages that were distributed in May and November 2002.

The monthly Medi-Cal Bulletin also includes Family PACT updates for both front and back office staff. Be sure these Medi-Cal bulletins are circulating to all staff involved in delivering, documenting or billing for Family PACT services. This information is also available at www.medi-cal.ca.gov.

CDC SEXUALLY TRANSMITTED DISEASES TREATMENT GUIDELINES – 2002

CDC released new STD Treatment Guidelines in the MMWR, May 10, 2002, Vol. 51, No. RR-6. They are available electronically at http://www.cdc.gov/mmwr. These Guidelines provide the standard of practice for treating STD's that Family PACT providers are expected to follow. ■

Family PACT Provider Forums

Two forums are being scheduled for the winter/ spring of 2003, one in San Bernardino (2/28/03) and one in San Diego (4/29/03). Watch for publicity.

Regional forums are a town hall meeting for Family PACT providers and staff to have an open dialogue with other Family PACT providers and the Office of Family Planning leadership about various new issues and local concerns.

Forums are an exiting opportunity to:

- Network with local colleagues and meet OFP representatives;
- Receive updated county-based data, profiles of clients and provider services;
- Hear OFP clarification of the *Policies, Procedures and Billing Instruction* manual;
- Share your thoughts, challenges and solutions with other Family PACT providers and OFP representatives. ■

Did You Know?

The Family PACT website (www.FamilyPACT.org) is your online source for Family PACT information. A sample of what you can find:

- The *Policies, Procedures and Billing Instructions (PPBI)* manual
- Educational events calendar
- Provider Orientation and Update schedule
- Downloadable versions of Client Eligibility Certification (CEC) and the sterilization consent form. ■

Family PACT
Planning • Access • Care • Treatment
OFFICE OF FAMILY PLANNING
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

714 P Street, Room 440
Sacramento, CA 95814